**STATE OF TENNESSEE**

**DEPARTMENT OF COMMERCE AND INSURANCE**

**TENNCARE DIVISION**

CLAIMS PROCESSING
MARKET CONDUCT EXAMINATION

OF

# JOHN DEERE HEALTH PLAN, INC.

MOLINE , ILLINOIS

FOR THE PERIOD OCTOBER 1, 1999,
THROUGH DECEMBER 31, 1999

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DATE: October 15, 2001

A limited market conduct examination of claims processing of John Deere Health Plan, Inc. 408 North Cedar Bluff Road, Suite 400, Knoxville, Tennessee, 37923, was completed February 23, 2001. The report of this examination is herein respectfully submitted.

## I. FOREWORD

This report is a market conduct examination report "by test" of the claims processing system of John Deere Health Plan, Inc. ("JDHP"). A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

## II. PURPOSE AND SCOPE

### A. Authority

This examination of JDHP was conducted by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) under the authority of Section 3-6. of the Contractor Risk Agreement between the State of Tennessee and JDHP ("TennCare Contract"), Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

JDHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

### B. Market Conduct Area Examined and Period Covered

This examination focused on the claims processing functions and performance of JDHP. Fifty claims were selected for testing from paid and denied claims processed by JDHP from October 1, 1999, through December 31, 1999. The fieldwork was performed via a combination of an onsite visit, telephone interviews and U.S. Mail transmissions from May 8, 2000, through February 28, 2001.

### C. Purpose and Objective

The purpose of the examination was to obtain assurance that JDHP's claims operations were administered in accordance with the TennCare Contract as well as state statutes regulating HMOs.

The objectives of this examination were to:

- Determine whether JDHP met its contractual obligations under the TennCare Contract and whether JDHP was in compliance with the regulatory requirements for HMOs set forth in Tennessee Code Annotated ("TCA") §§ 56-32-201 et seq.;

- Determine whether JDHP properly adjudicated claims from service providers and made payments to providers in a timely manner; and

- Determine whether JDHP had corrected deficiencies outlined in prior reviews of JDHP conducted by the Comptroller of the Treasury ("Comptroller") or examinations conducted by TDCI.

## III. PROFILE

### A. Brief Overview

Heritage National Healthplan, Inc. ("HNHI"), an Illinois HMO, was incorporated under the laws of the State of Illinois on August 5, 1985, and was certified as an HMO by the State of Illinois Department of Insurance in 1985. HNHI was certified as an HMO by the State of Tennessee Department of Commerce and Insurance on June 20, 1995. HNHI is a wholly-owned subsidiary of John Deere Health Care, Inc., which is a wholly-owned subsidiary of Deere & Company.

Heritage National Healthplan of Tennessee, Inc. ("HNHT"), a Tennessee Health Maintenance Organization ("HMO"), was incorporated under the laws of the State of Tennessee on October 25, 1985, and was thereafter certified as an HMO by the State of Tennessee Department of Commerce and Insurance on July 1, 1986. Under its license, HNHT administered commercial plans and also participated as a contracted HMO in the TennCare program.

On September 10, 1996, Heritage National Healthplan of Tennessee, Inc. submitted to the State of Tennessee Department of Commerce and Insurance a proposed plan to merge with and into Heritage National Healthplan, Inc. On November 18, 1996, the merger of HNHT with and into HNHI was approved by the Commissioner of the Tennessee Department of Commerce and Insurance to be effective December 31, 1996.

HNHT participated in the State's TennCare Program beginning in January 1994 and effective December 31, 1996, concurrent with the merger into HNHI, HNHT's TennCare Contractor Risk Agreement was assigned to HNHI. Effective July 1, 1999, HNHI changed its name to John Deere Health Plan, Inc. JDHP is managed by John Deere Health Care, Inc., pursuant to a service agreement.

JDHP is currently authorized by TDCI and the TennCare Bureau to operate in the Eastern Grand Region. JDHP derives the majority of its revenue in the form of premium payments from its commercial line of business. JDHP received 12.2% of

its total 1999 revenue and 32.5% of its 1999 Tennessee revenues from capitation payments from the State of Tennessee for providing medical benefits to TennCare members. As of December 31, 1999, JDHP had approximately 34,015 TennCare members.

B. Claims Processing Not Performed by MCO

During the period under examination, JDHP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Doral Dental for dental services, and
- Davis Vision for vision services.

Because subcontractors processed the claims for these benefits, claims for these types of services were not included in JDHP's pool of claims from which claims were selected for testing. Therefore, no pharmacy, dental or vision claims were tested for compliance with the TennCare Contract and TCA § 56-32-226 ("the Prompt Pay Act").

## IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing and internal control deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period April 1, 1996, through December 31, 1997.

The following deficiencies were noted in the prior examination:

- Not all claims were processed in accordance with Section 2-18. of the TennCare Contract.
- Not all claims were correctly priced and paid.
- Claims were pended in excess of 60 days.
- Not all claims were properly input into the system.
- EOBs incorrectly indicated member liability.
- Coinsurance collected by ARGUS, the subcontracted pharmacy claims processor, were not coordinated with coinsurance collected by Heritage National Health, Inc., the former name of John Deere Health Plan, Inc.

HNHI responded by stating that a new organizational structure was implemented to insure that employees were trained in claims processing.

HNHI was also asked to explain how the MCO planned to coordinate coinsurance with ARGUS. HNHI responded by providing Claims Status Reports for October and November 1998 that contained no claims pended in excess of 60 days. In addition, HNHI implemented procedures to eliminate the coinsurance from pharmaceutical claims, a process that eliminated the coordination problem.

## V. SUMMARY OF PERTINENT FACTUAL FINDINGS

### A. Summary of Deficiencies

The following deficiencies were determined to exist during the claims processing market conduct examination of JDHP for the period October 1, 1999, through December 31, 1999:

1. JDHP did not process all claims selected for testing in accordance with the TennCare Contract. Only 44 of 50 claims in the sample were processed within 60 days. Furthermore, in April 2001, JDHP did not process all claims within 60 days of receipt. The TennCare Contract requires an MCO to process 100% of all claims within 60 days.

2. One of the 26 paid claims was not paid in accordance with the information on the payment system

3. One claim was processed for a person who was not a JDHP enrollee.

4. JDHP did not apply the 180 day timely filing requirement to hospital claims.

5. The current pend report identified 12 claims that had been in JDHP's possession for more than 60 days.

6. The explanation of benefits provided to enrollees did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected for testing.

7. The written notice of the results of the claims adjudication given to providers did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected for testing

8. Six of the claims were not stamped with the date received.

## VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING SYSTEM

### A. Claims Selected For Testing

1. JDHP provided a datafile of paid and denied claims for the period October 1, 1999 through December 31, 1999. The total amount paid per the datafile was reconciled to the JDHP check registers and debit memos issued for the period October 1, 1999 through December 31, 1999 to within an acceptable level. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From the datafile, 50 claims were judgmentally selected for testing as follows:

   - One claim for each of the 7 claim types represented in the sample;
   - Ten denied or adjusted emergency room claims;
   - Five claims with coinsurance or deductibles;
   - Eighteen claims randomly selected from the claims which paid $0; and
   - Ten claims randomly selected from the claims that paid amounts greater than $0.

### B. Time Study of Claims Processing

1. The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames accorded in Section 2-18. of the TennCare Contract and the Prompt Pay Act . Section 2-18. of the TennCare Contract requires an MCO to process 95% of "clean" claims submitted by both contract and non-contract providers within 30 calendar days of receipt, the remaining 5% of "clean" claims within the next 10 calendar days, and 100% of *all* claims (clean or not clean) within 60 calendar days. A clean claim is defined as a claim which requires no further information, adjustment, or alteration by the provider of the service in order to be processed and paid by the MCO. The term "process" means that the MCO must either:

   - Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

   - Deny the claim, with ***all specific reasons*** for the denial communicated to the provider; or

- Advise the provider that there is insufficient information to adjudicate the claim and detail the *specific* information needed to adjudicate the claim.

2. The Prompt Pay Act requires that 90% of clean claims be processed, and if appropriate paid, within 30 days of receipt and that 99.5% of all provider claims be processed within 60 days of receipt.

   The processing and efficiency requirements of the TennCare Contract were applied to the 50 claims tested. For denied claims, the date that the provider remittance advice was printed was considered the final process date. Paid Claims correctly reflected the provider remittance date as the final process date.

   The timeliness testing applied to the 50 selected claims found that JDHP processed only 44 within 60 days of receipt; therefore, JDHP was not in compliance with Section 2-18 of the TennCare Contract because 100% of all claims were not processed within 60 days of receipt.

   Because the 50 claims tested were not selected using a statistical sampling method, the results of the timeliness test for processing "clean" claims could not be projected to the total population of claims processed by JDHP during the period October 1, 1999 through December 31, 1999. Therefore, it was not determined whether, during the test period, JDHP complied with the TennCare Contract's requirement to process 95% of "clean" claims within 30 days of receipt and the remaining 5% of "clean" claims within the next 10 days of receipt.

3. On April 12, 2001, TDCI requested a data file from all MCOs containing **all** claims processed during the month of April 2001. This data file was used to determine each MCO's compliance with the processing requirements defined in the TCA § 56-32-226(b) and Section 2-18 of the TennCare Contract. Because these tests were performed on all claims processed in April 2001, no projections to the population are needed.

   During the month of April 2001, JDHP processed 96.82% of all claims within 30 days and 99.77% of all claims within 60 days.

   TCA § 56-32-226(b) requires that 95% of all claims be processed with in 30 days and that 99.5% of all claims be processed with in 60 days. In April 2001, JDHP met the timeliness standards set forth in TCA § 56-32-226(b). Section 2-18 of the TennCare Contract requires that 100% of all claims be processed within 60 days. JDHP did not met the timeliness standards set forth in Section 2-18 of the TennCare Contract during April 2001.

Management's Response:

John Deere Health concurs with the finding. A workflow, imaging and customer service system was implemented in August 2001. This system allows for entry and indexing of claim images plus automatically schedules work by age date order. Eliminating manual distribution of work increases claim-processing efficiency, which will assist in meeting TennCare Contract requirements. Customer Support also continually reminds staff to change the received date on adjustments, which impacts claim turnaround. In addition, as each claim is scanned, the received date is affixed to the claim image.

C. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

1. One of the 26 paid claims was not paid in accordance with the information on the payment system. The provider was to be paid at a rate of 50% of the amount billed. JDHP paid $25 more than the established rate.

   Management's Response:

   The specific claims payment notation referenced in the report has been changed in the John Deere Health system. Therefore, JDH concurs with the finding, as no additional information can be obtained to clarify claim payment.

2. JDHP erroneously received a claim for a person who had commercial insurance through another company. JDHP, however, processed this claim under the name of one of its TennCare enrollees.

   Management's Response:

   John Deere Health concurs with the finding. Customer Support staff has received training to avoid processing similar names under the eligible member name/identification number.

3. One hospital claim was paid even though it was received more than 180 days after the last date of service. JDHP does not impose the 180-day requirement on hospital providers. Section 2-18 jj. of the TennCare Contract states:

   > a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR and no more than one hundred eighty (180) calendar days

from the date of rendering a health care service to file an initial claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date.

Further JDHP's contract with hospital providers states in Section 3, Billing Requirements that "c. Contracting Hospital agrees that all medical services provided to a TennCare Member will be billed to JDHP within 180 days of the date services were rendered or, if later when Contracting Hospital determines JDHP as primary payor."

Management's Response:

John Deere Health concurs with the finding.

D. Withhold, Deductible and Coinsurance Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. Five withhold percentages were compared to the percentages in the providers' contracts. No discrepancies were noted.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments on certain procedures, whether out-of-pocket payments are within liability limitations, and whether out-of-pocket payments are accurately calculated in accordance with Section 2-3.k of the TennCare Contract.

   Information was obtained from the TennCare Bureau concerning the coinsurance requirements for each enrollee selected in the sample. This information was compared to the information JDHP had recorded in its system. No discrepancies were noted.

3. Five claims with a coinsurance calculation were included in the claims selected for testing. The coinsurance was correctly calculated and enrollees' out-of-pocket costs were accumulated accurately.

E. Suspended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been suspended or pended by JDHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. JDHP provided the examiners a HCFA and UB

pended claims report as of October 31, 2000. JDHP reported a total of 4,977 pended claims of which 12 were already over 60 days old. The oldest claim had been in process for 154 days. JDHP is out of compliance with Section 2-18 of the TennCare Contract which requires all claims to be processed within 60 days. The small number of claims on the pend report suggests that JDHP did not have a material unrecorded liability at October 31, 2000.

Management's Response:

John Deere Health concurs with the finding. A workflow, imaging and customer service system was implemented in August 2001. This system allows for entry and indexing of claim images plus automatically schedules work by age date order. Eliminating manual distribution of work increases claim-processing efficiency, which will assist in meeting TennCare Contract requirements. Customer Support also continually reminds staff to change the received date on adjustments, which impacts claim turnaround. In addition, as each claim is scanned, the received date is affixed to the claim image.

F. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductible and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices.

JDHP provides EOBs to enrollees whose claims are subject to deductible and/or coinsurance. The examiners requested EOBs for the 5 claims tested for coinsurance. Discrepancies between the information recorded in the claims processing system and the information reported on the EOB were found in 4 of the 5 EOBs tested.

- The claims processing system indicated one claim was denied for "No COB with Medicare." The EOB supplied to the enrollee did not indicate that Medicare was responsible for the claim, but indicated that the enrollee was responsible for the uncovered services.

- The information reported on one EOB was incomplete because it did not include all the claim information (e.g. all services billed, the amounts paid for those services, etc.) Further, the claim was denied with the notation "Bill PBHS." PBHS represents Premier Behavioral Systems of Tennessee, LLC., a Behavioral Health Organization ("BHO") assigned to provide mental health services to JDHP's TennCare enrollees. The EOB sent to the enrollee did not indicate that the BHO was responsible for the claim, but indicated that the enrollee was responsible for the uncovered services.

- The patient liability on one EOB differed from the liability in the claims system by $.40.

- One EOB did not contain any information related to the processed claim. There was no information regarding the services provided to the enrollee or the benefits paid to the provider.

Management's Response:

John Deere Health concurs with the finding that there was conflicting information on the EOBs. The Explanation of Benefits indicates that there is patient liability however, the remarks field provides a description of denial and the course of action that needs to be taken, i.e. " No John Deere Health Care Benefits (Medicare) – submit to the State of Tennessee TennCare". A team has been formed to review denial reason codes and how the system is programmed to identify codes which are incorrectly driving dollars into the "patient owes to provider of service" field on the Explanation of Benefits.

G. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

T.C.A. § 56-32-226(b) requires an HMO to pay 90% of claims within 30 days of receipt and to process, and if appropriate, pay 99.5% of claims within 60 days of receipt. T.C.A. § 56-32-226(b)(1)(B) states that "process" means the HMO will send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally denied and specify all known reasons for the denial.

The examiners requested the remittance advices for 5 claims tested. JDHP did not provide remittance advices for 3 of the 5 claims. Per JDHP, remittance advices were not generated because these 3 claims did not result in payments to the providers because the enrollees' deductible and/or coinsurance covered the cost of the service. Further investigation revealed that all providers are sent a copy of the EOB that is sent to the enrollee, therefore JDHP has properly notified its providers in accordance with 56-32-226(b).

It is noted that the same errors described in Paragraph VI.F of this report are applicable to the EOBs sent to the providers. Providers are being informed that an enrollee has a payment liability when in fact the enrollee has none.

Management's Response:

John Deere Health concurs with the finding that there was conflicting information on the EOBs. The Explanation of Benefits indicates that there is patient liability however the remarks field provides a description of denial and the course of action that needs to be taken, i.e. " No John Deere Health Care Benefits (Medicare) – submit to the State of Tennessee TennCare". A team has been formed to review denial reason codes and how the system is programmed to identify codes which are incorrectly driving dollars into the "patient owes to provider of service" field on the Explanation of Benefits.

H. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the actual payment of claims by JDHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for five claims. These checks cleared the bank within 10 days of issuance by JDHP.

I. Comparison of Actual Claim with System Claim Data

The purpose of comparing hard copy claims with the data entered into the claims system is to ensure that the claims data received by JDHP is accurately entered into the claims system for purposes of accurate claims adjudication and encounter data reporting to the TennCare Bureau.

The examiners requested the 50 original claims selected for testing. JDHP provided copies of all 50 claims. The data elements from the 50 claims were compared to the data elements entered into JDHP's claims processing system.

Six of the claims did not exhibit a date stamp, thus, the date received recorded in the system could not be verified.

Management's Response:

John Deere Health concurs with the finding. A workflow, imaging and customer service system was implemented in August 2001. This system allows for entry and indexing of claim images via automated date stamping. Customer Support also continually reminds staff to change the received date on adjustments, which impacts claim turnaround. In addition, as each claim is scanned, the received date is affixed to the claim image.

J. Electronic Claims Capability

Section 2-18. of the TennCare Contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …".

Section 2-2.g. of the TennCare Contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. JDHP has implemented an electronic billing option for claims submission by providers and estimates that approximately 52% of their providers made use this option as of December 31, 2000. JDHP was in compliance with the TennCare Contract.

## VII. REPORT OF OTHER FINDINGS AND ANALYSES

A. Weekly Claims Processing Reports

The September 17, 1999 weekly claims processing report was selected for review and JDHP was requested to provide supporting documentation for this report. No deficiencies were noted in the weekly claims processing report.

B. Provider Complaints to TDCI Regarding Claims

At the on-site visit in Knoxville, TN, the provider complaint logs maintained by JDHP were reviewed. Six complaints were selected for review. JDHP responded to all 6 complaints reviewed within the required 60-day time frame stipulated in TCA § 56-32-226(b)(2).

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of JDHP.